

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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(M)

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06542

## CERTIFICATE OF DEATH

06527

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East		c. LENGTH OF STAY IN 1b 1 yr. 8mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home				d. STREET ADDRESS R.D. 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LUTHER B. AKERS				4. DATE OF DEATH May 29 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Mercer Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James F. Akers				14. MOTHER'S MAIDEN NAME Polly E. McCommas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-36-3704		17. INFORMANT Vernon A. Akers		Address R.D. 1 Box 78 North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Bleeding Gastric Ulcer</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 days</u> <u>17 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (1) (this hospital) attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>29 May</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>28 May</u> 19 <u>67</u> , and that death occurred at <u>12:30 P.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Klaus H. Huebner</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/29/67</u>	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER				22d. ADDRESS NORTH EAST, MD			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/67	23c. NAME OF CEMETERY OR CREMATORY Friends Burying Grounds		23d. LOCATION (City or Town)		(County) (State) Cecil Md.	
24. FUNERAL DIRECTOR Grant Funeral Home				ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR DATE JUN 1 1967	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

78032

UNITED STATES DEPARTMENT OF AGRICULTURE

01200

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06528

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural North East c. LENGTH OF STAY IN 1b 29 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural North East d. STREET ADDRESS R.D. 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last AGNES B. BENJAMIN		4. DATE OF DEATH Month Day Year May 18 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1907
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Fancy Gap, Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jacob C. Bailiff	
14. MOTHER'S MAIDEN NAME Mary E. Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Otis B. Benjamin	
Address R.D. 1 North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor : Glioblastoma multiforme 1930 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 21 Sept, 1968, to 18 May, 1967, that (I) (we) last saw the deceased alive on 17 May 1967, and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Klaus H. Huebner		22b. DATE SIGNED 5/18/67	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER		22d. ADDRESS NORTH EAST, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/67	
23c. NAME OF CEMETERY OR CREMATORY Bay View Methodist		23d. LOCATION (City, town or county) Cecil County Md.	
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR MAY 22 1967	
ADDRESS Box 22 North East, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

06544

06529

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, Rural</b>		c. LENGTH OF STAY IN 1b <b>Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R. F. D. # 1</b>			d. STREET ADDRESS <b>R. F. D. # 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Charlotte Arminta Boyd</b>			4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5--28--1979</b>		9. AGE (In years last birthday) <b>87</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Raven Virginia</b>	
13. FATHER'S NAME <b>Henry W. Van Dyke</b>			14. MOTHER'S MAIDEN NAME <b>Lucinda Webb</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-46-8647</b>		17. INFORMANT <b>Isaac Boyd Rising Sun, Md. (Son)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of G.I. tract</b> DUE TO <b>Hepato megalia...</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 1966</b> to <b>May 1967</b> , that (I) (we) last saw the deceased alive on <b>May 19 1967</b> , and that death occurred at <b>5:30 AM</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Ernest W. Seiter M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 22, 1967</b>
22c. PHYSICIAN'S NAME (Type) <b>Ernest W. Seiter M. D.</b>			22d. ADDRESS <b>28 Cherry St. Rising Sun, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-24-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Port Deposit Cecil Md.</b>	
25a. REC'D BY REGISTRAR <b>MAI 23 1967</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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**FUNERAL DIRECTOR**  
*[Signature]* Div. **Tyson Funeral Home**  
**Rising Sun, Md.**

00344

CONTINUED OF LIST

Serial

Classification

Control

Personal

Religious

Leaves

Records

State

Other

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06545

CERTIFICATE OF DEATH

06530

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia		d. STREET ADDRESS 3352 Disston St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles C. BRADFORD		4. DATE OF DEATH Month May Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-23-87
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles C. Bradford (Deceased)		14. MOTHER'S MAIDEN NAME Mary Collins (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 169-12-36-40	
17. INFORMANT VA Hospital Records - Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to aspiration of Gastric Content AND Broncho Pneumonia of both lower lobes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 Min. 5-10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from 5-10-67, 19 to 5-13-67, 19, and that death occurred at 5:50 p.m., from causes and on the date stated above.			
22a. SIGNATURE Ben Rothfeld		22b. DATE SIGNED 5 14 67	
22c. PHYSICIAN'S NAME (Type) BENJ. ROTHFELD, M.D.		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL PERMIT (Specify) Burial	23b. DATE THEREOF May 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Philadelphia, Penna.
24. FUNERAL DIRECTOR John J. McFarland		25a. REC'D BY REGISTRAR MAY 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME	

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100-33

RECORD OF DEEDS

Date	Description	Amount	Payee
1901	...	...	...
1902	...	...	...
1903	...	...	...
1904	...	...	...
1905	...	...	...
1906	...	...	...
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1910	...	...	...
1911	...	...	...
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1914	...	...	...
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1921	...	...	...
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1924	...	...	...
1925	...	...	...
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1929	...	...	...



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
06546		CERTIFICATE OF DEATH				06531			
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> <b>District of Columbia</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>200 Trenton Place, SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>CLARENCE F. BURR</b>			4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 67</b>		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <b>7-5-84</b>			9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office worker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cream Ridge, New Jersey</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>John Burr (D)</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Atkinson (D)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>VA Hospital Records, Perry Point, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>and</b> (b) <b>Carcinoma of right lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>6-12 mos.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6-12 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 2</b> , 1967, to <b>May 12</b> , 1967, <del>that the deceased died at the residence of the deceased</del> and that death occurred at <b>8:50 am</b> , from causes and on the date stated above.									
22a. SIGNATURE <i>J. R. Garcia M.D.</i>				22b. DATE SIGNED <b>5-12-67</b>		22c. PHYSICIAN'S NAME (Type) <b>J. R. GARCIA, M.D.</b>			
22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE THEREOF <b>May 15, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Long Island National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Pineblawn, Long Island, N.Y.</b>		24. FUNERAL DIRECTOR <b>Lee A Patterson &amp; Son Funeral Home, Perryville, Maryland</b>			
25a. REC'D BY REGISTRAR <b>MAY 19 1967</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

15220

2000

06547

**CERTIFICATE OF DEATH**

06532

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit - Rural</u>			c. LENGTH OF STAY IN TB <u>Life</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit - Rural</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Craigtown Road</u>				d. STREET ADDRESS <u>Craigtown Road</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Viola</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>May</u> Day <u>25</u> Year <u>1967</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 6, 1892</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles S. Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Martha H. Donahoo</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Robert J. Campbell, Port Deposit, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Cerebral Sclerosis</u> DUE TO (c) <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>16 months</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Accident: Paralysis Left Side - June - Jan 19-66</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19, 1966</u> , to <u>May 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 25, 1967</u> , and that death occurred at <u>11:20 M.</u> from causes and on the date stated above.								
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May-26-1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>				22d. ADDRESS <u>Port Deposit, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, Md.</u>		
24. FUNERAL DIRECTOR <u>Lee A. Patterson &amp; Son, Perryville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove far papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06548

06535

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY in 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>105 DEL. AVE.</u>		d. STREET ADDRESS <u>105 DEL. AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>THOMAS</u>		4. DATE OF DEATH <u>5</u> <u>2</u> <u>1967</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-11-1894</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. GOVT. WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>STANTON, DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY CARR</u>		14. MOTHER'S MAIEN NAME <u>SARAH MANN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>169-20-1490</u>	
17. INFORMANT <u>MOELLIE A. CARR</u>		Address <u>ELKTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Brain Disease</u> 334X Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last, (b) <u>QUE TO</u> (c) <u>QUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1940</u> to <u>May 2, 1967</u> that (I) (we) last saw the deceased alive on <u>May 2, 1967</u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry V. Davis</u>		22b. DATE SIGNED <u>5/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS MD</u>		22d. ADDRESS <u>CHESAPEAKE CITY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-6-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GILPIN MANOR MEM. PK.</u>		23d. LOCATION (City, town or county) (State) <u>ELKTON, MD.</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 5 1967</u>	

88529

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06543

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06534

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Cecil Co.</b> b. COUNTY <b>Md.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit Rural</b>		c. LENGTH OF STAY IN Tb <b>2 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit 07-1 Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dr. Jack Rd.</b>			d. STREET ADDRESS <b>Dr. Jack Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>William Rowland Christie</b>			4. DATE OF DEATH <b>May 1 19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1882</b>	9. AGE (In years last birthday) yrs. <b>85</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Hand</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Robert Christie</b>			14. MOTHER'S MAIDEN NAME <b>Mary S. Cooley</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-32-4093</b>	17. INFORMANT Address <b>Miss Frances Taylor Conowingo Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Name Known</b>					INTERVAL BETWEEN DEATH <b>Yrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>April 5-1-19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Tillman D. Johnson</b> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>Tillman D. Johnson M.D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, city, town, or county) <b>Fulton Md 5-1-67</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-3-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Near. Colora Cecil Md.</b>
24. FUNERAL DIRECTOR <b>W. H. Muller 1950 N. 7th St. Dir.</b>			25a. REC'D BY REGISTRAR <b>MAY 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**06550**

**CERTIFICATE OF DEATH**

**06535**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington, D.C.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Md.</b>		c. LENGTH OF STAY IN 1b <b>59 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VAH Perry Point, Md.</b>			d. STREET ADDRESS <b>4248 Dix St., N.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>James H. Cole</b>			4. DATE OF DEATH Month Day Year <b>May 28 1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 10 97</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waiter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>James H. Cole Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Georgianna Taft</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>579-10-3350</b>		17. INFORMANT <b>VA Hospital Records.</b> Address <b>Perry Point, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>METASTATIC CANCER TO CERU. SPINE</b> DUE TO (c) <b>CANCER OF LT. LUNG</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b> <b>1 yr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>QUADROPLEGIA, DECUBITAL ULCERS</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (a) (this hospital) attended the deceased from <b>3-30</b> , 19 <b>67</b> to <b>5 28</b> , 19 <b>67</b> and that death occurred at <b>2:55 A.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>Stephen A. Hegedus</b>			22b. DATE SIGNED <b>5-28-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>STEPHEN A. HEGEDUS, M.D.</b>			22d. ADDRESS <b>VA Hospital - Perry Point, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>6-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat</b>	23d. LOCATION (City or Town) (County) (State) <b>Cotonville Md</b>		
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; Son 4925 Maine Ave NE</b>			25a. REC'D BY REGISTRAR DATE <b>JUN 2 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

DISPATCHES OF 1941

00570

DISPATCHES OF 1941

DISPATCHES OF 1941

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06551

CERTIFICATE OF DEATH

06536

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b> c. LENGTH OF STAY IN 1b <b>Life</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.F.D. # 1</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rising Sun Rural</b> d. STREET ADDRESS <b>R.F.D. # 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nancy Alice Cox</b> First Middle Last		4. DATE OF DEATH <b>May 8, 1967</b> Month Day Year	
5. SEX <b>M Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>June 7, 1876</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Floyd Co. Virginia</b>
13. FATHER'S NAME <b>Costly Hill Puckett</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>*****</b>	
17. INFORMANT <b>Virginia Mae Wiggins</b>		Address <b>Rising Sun, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension &amp; Coronary Disease</b> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <b>Cardio decompensation</b> DUE TO (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-24</b> , 19 <b>67</b> , to <b>5-8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5-8</b> , 19 <b>67</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>G.H. Richards</b>		22b. DATE SIGNED <b>5/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G.H. Richards</b>		22d. ADDRESS <b>Port Deposit Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-11-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brookview Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Rising Sun, Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. H. Tyson</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>MAY 11 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06552

CERTIFICATE OF DEATH

08018

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Passaic</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Paterson</b>		d. STREET ADDRESS <b>269 Kearney Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernadine L. Crosby</b>		4. DATE OF DEATH Month Day Year <b>May 31, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1916</b>
9. AGE (In years last birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physio-Therapist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Marie O'Farrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>217-12-6671</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic heart disease</b> (c) <b>Arteriosclerosis, generalized</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <b>May 23, 1967</b> to <b>May 31, 1967</b> , and that death occurred at <b>8:00 am</b> from causes and on the date stated above.			
22a. SIGNATURE <b>S. Goldgraben</b>		22b. DATE SIGNED <b>6-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VAH, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/3/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Landon Park National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son Funeral Home, Perryville</b>		25a. REC'D BY REGISTRAR <b>JUN 7 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06553

06537

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>	
c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		d. STREET ADDRESS <u>MOSS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HIRAM</u> First Middle Last <u>EVERETT</u>		4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-22-82</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MILLINGTON, M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN J. EVERETT</u>		14. MOTHER'S MAIDEN NAME <u>EMILY JANE COLE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-16-4729</u>	
17. INFORMANT <u>ANN ELIZABETH EVERETT</u>		Address <u>CHESAPEAKE CITY, M.D.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>CACHEXIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>40 DAYS</u> <u>SEVERAL YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 10</u> , 19 <u>66</u> , to <u>MAY 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAY 22</u> , 19 <u>67</u> , and that death occurred at <u>7:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Henry J. Davis</u>		22b. DATE SIGNED <u>5/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry J. Davis M.D.</u>		22d. ADDRESS <u>CHESAPEAKE CITY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5-25-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>	23d. LOCATION (City or Town) (County) (State) <u>CHESAPEAKE CITY, MD.</u>
24. FUNERAL DIRECTOR <u>Robert Howard</u> <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>Charles Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		25c. DATE <u>MAY 25 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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LIBRARY  
540 EAST 58TH STREET  
CHICAGO, ILL. 60637  
TEL: 773-936-5000  
WWW.CHICAGO.EDU

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

06554

06538

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence, State, County, City or Town) e. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>16 yrs</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>104 Walnut Lane</b>			
3. NAME OF DECEASED (Type or print) <b>ANTHONY PETER FABRIZI, Jr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>30</b> Year <b>1967</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 2, 1950</b>	
9. AGE (In years last birthday) <b>16 yrs.</b>		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>16</b>		11. IF UNDER 24 HRS. Hours <b>16</b> Min. <b>59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Elkton, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Anthony Peter Fabrizi, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Jane Shepardson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Anthony Peter Fabrizi, Sr., Elkton, Md.</b>			
17. INFORMANT <b>Anthony Peter Fabrizi, Sr., Elkton, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> <b>7540</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Ventricular Fibrillation</b> (a), stating the underlying cause last. (c) <b>Pulmonary Embolism - Intracardial - ventricular fibrillation</b> <b>16 yrs.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b> <b>8 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 19, 1967</b> to <b>May 30, 1967</b> , that (I) (we) last saw the deceased alive on <b>May 30, 1967</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph G. Lanzi, M.D.</b>				22b. DATE SIGNED <b>5/30/67</b>		22c. PHYSICIAN'S NAME (Type) <b>Joseph G. Lanzi, M.D.</b>	
22d. ADDRESS <b>Elkton Medical Park, Elkton, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 2, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception</b>		23d. LOCATION (City, town or county) (State) <b>Cherry Hill, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hicks Home for Funerals, Elkton, Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 5 1967</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>	

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Sept. 2, 1980

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U. S. A.

Winton, Maryland

Student

Jane Sheppard

Anthony Peter Ferial, Sr.

Anthony Peter Ferial, Sr. Winton, Md.

No

Winton Medical Farm, Winton, Md.

Joseph D. Ferial, M.D.

Enlist June 2, 1987 Winton, Maryland

Wicks Home for Pioneers, Winton, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06555

06539

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Elkton		d. STREET ADDRESS Cherry Hill R.D. 5 (Elkton)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elsie First Middle Lost Lorenda Gallimore		4. DATE OF DEATH Month 5 Day 24 Year 19 67	
5. SEX F	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-55
9. AGE (In years lost birthday) yrs. 11		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
11. BIRTHPLACE (State or foreign country) Harre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Gallimore		14. MOTHER'S MAIDEN NAME Alvenia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. Alvenia Nycum, R.D. #5 Box 137 Elkton Md.		18. INTERVAL BETWEEN ONSET AND DEATH Immed.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by car while riding bicycle on hwy.			
20c. TIME OF INJURY Month, Day, Year 7:55 p.m. 5-24 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rte 280 (Hwy)		20f. (City or town) (County) (State) Near Cherry Hill, Cecil, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED 5-24-67 Elkton, Md.		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
24. FUNERAL DIRECTOR Pippin Funeral Home, 1001 W. 1st St. Elkton, Md.		25. REC'D BY REGISTRAR DATE MAY 31 1967	
26. REGISTRAR'S SIGNATURE Charles Judge		27. BIRTHPLACE (State or foreign country) Harre de Grace, Md.	

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UNITED STATES DEPARTMENT OF AGRICULTURE

14-00000

UNITED STATES DEPARTMENT OF AGRICULTURE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06556

CERTIFICATE OF DEATH

06540

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>6 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre De Grace</b>		d. STREET ADDRESS <b>653 Green St.,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>W.</b> Last <b>GIBSON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-24-00</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Philadelphia Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ernest H. Gibson (D)</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth HACKNEY (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>220-07-87-79</b>	
17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO (b) <b>Cerebral hemorrhage, massive</b> DUE TO (c) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>3-5 days</b> <b>6-7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>5-24-67</b> , 19 <b>5/30/</b> , 19 <b>67</b> , that (2) (we) lost <del>the deceased on</del> <b>5/30/1967</b> , and that death occurred at <b>10:20pm</b> from causes and on the date stated above.			
22a. SIGNATURE <b>S. Goldgraben</b>		22b. DATE SIGNED <b>5-31-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>JUNE 3, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Havre de Grace Md. Harford Co.</b>
24. FUNERAL DIRECTOR <b>R. Madison Mitchell, 123 W. Washington St.,</b>		25a. REC'D BY REGISTRAR <b>JUN 8 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 9 Film G388 5/11/67 kk  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06557

06541

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.D. 1</b>		d. STREET ADDRESS <b>R.D. 1</b>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>EVELYN</b> Last <b>HARPER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1926</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Robert Lee Harper</b>		14. MOTHER'S MAIDEN NAME <b>Della Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Stanley R. Harper Jr.</b> Address <b>Elkton, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot wound of neck and spinal cord</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot during altercation.</b>	
20c. TIME OF INJURY Hour <b>XX</b> p.m. <b>5/5</b> 19 <b>67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>North East Cecil Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		22. DATE SIGNED <b>5/6/67</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist</b>	23d. LOCATION (City or Town) (County) (State) <b>North East Cecil Md.</b>
24. FUNERAL DIRECTOR <b>Grant Funeral Home</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06558

06542

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN IT <b>1 mo 12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1717 Q Street, N. W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE E. HICKS</b>		4. DATE OF DEATH Month Day Year <b>May 18 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-23-92</b>
9. AGE (In years lost birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Benjamin F. Hicks (D)</b>		14. MOTHER'S MAIDEN NAME <b>Sarah E. Jackson (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>579-18-4271</b>	17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) <b>Arteriosclerotic heart disease</b> (c) <b>Arteriosclerosis, generalized</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>April 6, 19 67</b> to <b>May 18, 19 67</b> , that (X) (the deceased) died on <b>May 18, 19 67</b> , and that death occurred at <b>6:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>SEYMOUR GOLDGRABEN</b>		22b. DATE SIGNED <b>5-18-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>SEYMOUR GOLDGRABEN</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 23, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Switzland, Maryland</b>
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS FUNERAL HOME, WASHINGTON, DC</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1967</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06543

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>CECIL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>			c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>			d. STREET ADDRESS <b>R.D.3 (box 216-A)</b>		
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>EDWARD</b> Last <b>HILAMAN, Jr.</b>			4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1965</b>		9. AGE (In years lost birthday) <b>1</b> yrs. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <b>-----</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Edward Hilaman</b>			14. MOTHER'S MAIDEN NAME <b>Susan L. Church</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Robert E. Hilaman, Elkton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute epiglottitis and laryngitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>517X</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D. <b>Charles S. Springate, M.D.</b>		22. DATE SIGNED <b>May 8, 1967</b>	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/10/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Methodist</b>	
23d. LOCATION (City or Town) <b>Cherry Hill, Md.</b>		23e. REC'D BY REGISTRAR <b>MAY 15 1967</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>		ADDRESS <b>Hicks Home for Funerals, Elkton, Md.</b>			

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Robert Edward Williams  
Green I. Church  
Robert E. Williams, Nixon, Md.  
June 2, 1968  
D.A.A.  
Nixon, Md.

Robert E. Williams, Nixon, Md.  
June 2, 1968  
Green I. Church  
Nixon, Md.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
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06560  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06544

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Elkton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D. 1</u>		d. STREET ADDRESS <u>R.D. 1</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD</u> First <u>Fort</u> Middle <u>Gianniney</u> Last <u>Gianniney</u>		4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1924</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>	
11. BIRTHPLACE (State or foreign country) <u>Roncevert W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John B. Gianniney</u>		14. MOTHER'S MAIDEN NAME <u>Sally Sheets</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW 2</u>		16. SOCIAL SECURITY NO. <u>229-14-6393</u>	
17. INFORMANT <u>Ruby E. Gianniney</u>		Address <u>R.D. 1 Elkton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRRHOSIS OF THE LIVER</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CHRONIC ALCOHOLISM</u> (c) <u>  </u> (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DIED IN BED</u>	
20c. TIME OF INJURY Month, Day, Year <u>10/15/67</u> Hour a.m. <u>10:30</u> p.m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) <u>RT ELKTON</u> (County) <u>CECIL</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Henry V. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>HENRY V. DAVIS MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5/16/67</u>	
Address (Street, city, town, or county) <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/19/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>North East Meth</u>	22d. LOCATION (City, town, or county) <u>North East, Md.</u> (State) <u>  </u>
23. FUNERAL DIRECTOR <u>Paul R. Brouch</u>		24a. REC'D BY REGISTRAR <u>MAY 17 1967</u>	
ADDRESS <u>Box 22 North East, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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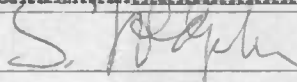
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

06561

**CERTIFICATE OF DEATH**

06545

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>HARTFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN TB <b>23 days</b> <b>1 yr 5 mos</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		d. STREET ADDRESS <b>669 Revolution Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL F. KIMBALL</b>		4. DATE OF DEATH Month Day Year <b>May 14 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-21-78</b>
9. AGE (In years last birthday) <b>89</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hartford Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel C. (D) KIMBALL</b>		14. MOTHER'S MAIDEN NAME <b>Annie R. Bradford (D)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes S A W</b>		16. SOCIAL SECURITY NO. <b>217-54-7552</b>	
17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO (b) <b>Arteriosclerotic heart disease and</b> <del>xxxx</del> <b>Obstructive uropathy</b> (c) <b>Very enlarge prostate</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1-2 weeks</b>  <b>years</b>  <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia, severe (refractory)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Nov. 22</b> , 19 <b>65</b> , to <b>May 14</b> , 19 <b>67</b> <del>xxxxxxx</del> <del>xxxxxx</del> and that death occurred at <b>10:30 pm</b> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>5-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>HAVRE DE GRACE MD.</b>
24. FUNERAL DIRECTOR <b>Madison-Mitchell</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>O'Connell, Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06562

CERTIFICATE OF DEATH

06546

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. # 1		d. STREET ADDRESS R.D. # 1	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph M. Kinslow		4. DATE OF DEATH Month Day Year May 8 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry T. Kinslow		14. MOTHER'S MAIDEN NAME Margaret L. Hammond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-12-9611	
17. INFORMANT Mrs. Blanche Kinslow, North East, Md		Address R.D. # 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hydronephrosis DUE TO (b) Diabetes, Chronic Nephritis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 7-Days 10-Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (husband) attended the deceased from 1/4/19 67, to 5/8/19 67, that (I) (we) last saw the deceased alive on 5/8/19 67, and that death occurred at 9:30 M, from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 5/9/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 East High St., Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/11/67	23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery	23d. LOCATION (City or Town) (County) (State) Zion, Cecil Co. Md.
24. FUNERAL DIRECTOR ADDRESS Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR DATE MAY 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
06563					CERTIFICATE OF DEATH					06547				
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville			c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rocks									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Perry Point V.A. Hospital					d. STREET ADDRESS North Bend Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MIDDLE Last ROBERT J. KNOPP					4. DATE OF DEATH Month Day Year May 21 1967									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5-22		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Ammunition			11. BIRTHPLACE (County & State, or foreign country) Rocks Harford MD			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph Knopp					14. MOTHER'S MAIDEN NAME Mary Dick									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II			16. SOCIAL SECURITY NO. 218 14 92 74		17. INFORMANT Wilson A. Knopp Address Rocks, Md. Perry Point, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema w/pleural effusion DUE TO Hepatic insufficiency DUE TO Cirrhosis of liver (Laennec's) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (this hospital) attended the deceased from 5-1-1967, to 5-21-1967, and that death occurred at 7:50 PM, from causes and on the date stated above.														
22a. SIGNATURE S. Goldgraben					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22b. DATE SIGNED 5-22-67				
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.					22d. ADDRESS VAH, Perry Point, Md., 21902									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-67		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Garden			23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.							
24. FUNERAL DIRECTOR MARTIN KURTZ & SON JARRETTSVILLE, MD.						25a. REC'D BY REGISTRAR DATE MAY 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge						



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06564

06548

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> <u>07-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>231 E. MAIN</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First Middle Last <u>A. LOVELESS</u>				4. DATE OF DEATH Month <u>5</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1895</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.H. HOSPITAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHESAPEAKE CITY, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DALLAS V. LOVELESS</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE R. LLOYD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-20-5331A</u>		17. INFORMANT <u>FRED B. LOVELESS</u>		Address <u>RD 41 ELKTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial insufficiency</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 h.</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/14/67</u> , 19 <u>67</u> , to <u>5-15-</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>5-15-</u> , 19 <u>67</u> , and that death occurred at <u>8:27</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>T. Johnson</u>				22b. DATE SIGNED <u>5-15-67</u>		22c. PHYSICIAN'S NAME (Type) <u>T. Johnson M.D.</u>	
22d. ADDRESS <u>123 Singers Ave., Elkton, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESAPEAKE CITY MD</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
06565					CERTIFICATE OF DEATH					06549				
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Chester									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert,					c. LENGTH OF STAY IN 1b 20 Months					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home					d. STREET ADDRESS 111 S. Fourth St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mrs Mary					4. DATE OF DEATH May 14, 1967									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-24-1883		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10b. KIND OF BUSINESS OR INDUSTRY Mushroom Cannery					11. BIRTHPLACE (County & State, or foreign country) Lionville, Chester Co U.S.A.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Edward Keeley					14. MOTHER'S MAIDEN NAME Mary Carney				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No.					16. SOCIAL SECURITY NO. 181-20-5762D					17. INFORMANT David W. McMahon				
										20 S. Fourth St Oxford, Pa.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. OUE TO (b) Carcinoma caecum OUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden 6 mo.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic mellitus										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)					20h. (State)				
21. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 5-14, 1967, that (I) (we) last saw the deceased alive on 5-14 1967, and that death occurred at 5:20 P.M. from the causes and on the date stated above.														
22a. SIGNATURE C.T. HOLCOMBE MD										22b. DATE SIGNED 5-15-67				
22c. PHYSICIAN'S NAME (Type) C.T. HOLCOMBE MD										22d. ADDRESS Oxford, Pa.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5-17-1967					23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery				
23d. LOCATION (City, town or county) West Grove, Penna.					23e. (State) Penna.									
24. FUNERAL DIRECTOR William J. Johnston					25a. REC'D BY REGISTRAR DATE MAY 17 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				

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1811-10-1882, David A. McMahon Oxford, Pa.

Oxford, Pa.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06566

CERTIFICATE OF DEATH

06550

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora Rural</b>		c. LENGTH OF STAY IN 1b <b>10 1/2 Years</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora Rural</b>		d. STREET ADDRESS <b>021</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marie Evans Morgan</b>		4. DATE OF DEATH <b>May 26 19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-11-1928</b>
9. AGE (In years lost birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Radford Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Allen Evans Croy</b>		14. MOTHER'S MAIDEN NAME <b>Grace Powers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>231-24-6525</b>	
17. INFORMANT <b>Frank Morgan</b>		Address <b>Colora Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3400 Meningitis</b> DUE TO (b) <b>Chl Strep</b> DUE TO (c) <b>10 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-18</b> , 19 <b>67</b> , to <b>5-26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5-26</b> , 19 <b>67</b> , and that death occurred at <b>3:30</b> AM, from causes and on the date stated above.			
22a. SIGNATURE <b>G. H. Richards Jr.</b>		22b. DATE SIGNED <b>5/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. H. Richards Jr. MD</b>		22d. ADDRESS <b>Port Deposit Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-29-1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colora Cecil Md.</b>	
24. FUNERAL DIRECTOR <b>Mr. Tyson</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Checked by: *Edwards* Deputy Medical Officer Cecil Corby

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MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06567

CERTIFICATE OF DEATH

06551

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Massey.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Helene W. NAYLOR		4. DATE OF DEATH Month 5 Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December, 11, 1881
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Own Home.	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward A. Woodall.		14. MOTHER'S MAIDEN NAME Agnes Kraft.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 214-46-4718	
17. INFORMANT Daughter.		Address Galena, Md. 21635	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 Arteriosclerosis, generalized DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (d) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fracture right hip; neck fracture		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/18, 1967, to 5/1, 1967, that (I) (we) last saw the deceased alive on 4/30, 1967, and that death occurred at 8:15 AM, from causes and on the date stated above.			
22a. SIGNATURE John A. Fischer		22b. DATE SIGNED 5/1/67	
22c. PHYSICIAN'S NAME (Type) JOHN A. Fischer		22d. ADDRESS ELKTON, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial.	23b. DATE THEREOF May, 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery.	23d. LOCATION (City or Town) (County) (State) Galena, Kent Co; Md.
24. FUNERAL DIRECTOR Edward Fellows,		25a. REC'D BY REGISTRAR MAY 4 1967	
ADDRESS Millington, Md. 21651		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

10101

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06568

CERTIFICATE OF DEATH

06552

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>DISTRICT OF COLUMBIA</b> COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		d. STREET ADDRESS <b>2101 16th St. N.W.</b>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary U. PIERCE</b>		4. DATE OF DEATH Month Day Year <b>May 4 1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-14-95</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>clerical</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Hopkinton, Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John F. Pierce</b>		14. MOTHER'S MAIDEN NAME <b>Anna Welch</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>059-03-7221</b>		
17. INFORMANT <b>VA Hospital Records - Perry Point, Maryland</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Coronary Heart Disease,</b> DUE TO <b>Severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Acute Myocardial Infarction</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				
21. I certify that <b>(B. Rothfeld)</b> attended the deceased from <b>3-29-65</b> , 19 <b>pm</b> to <b>5-4-67</b> , 19 <b>pm</b> , and that death occurred on <b>May 4 1967</b> , from causes and on the date stated above.				
22a. SIGNATURE <b>B. Rothfeld</b>		22b. DATE SIGNED <b>5-6-67</b>		
22c. PHYSICIAN'S NAME (Type) <b>B. ROTHFELD, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>May 8 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Benedict</b>	23d. LOCATION (City or Town) (County) (State) <b>Boston Dor. Mass</b>	
24. FUNERAL DIRECTOR <b>Cunningham Son</b>		25a. REC'D BY REGISTRAR <b>May 12 1967</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06563

CERTIFICATE OF DEATH

06553

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Veterans Administration Hospital</b>						e. STREET ADDRESS <b>1604 Latrobe Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>RICHARD PIERCE</b>						4. DATE OF DEATH Month Day Year <b>May 16 19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-25-12</b>		9. AGE (In years last birthday) yrs. <b>54</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick layer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Stevensville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William (D)</b>				14. MOTHER'S MAIDEN NAME <b>Maude Gross (D)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>216-12-1573</b>		17. INFORMANT Address <b>VA Hospital Records, Perry Point, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ <b>473 X</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Duration 1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>40</b> (this hospital) attended the deceased from <b>May 16</b> , 19 <b>67</b> , to <b>May 16</b> , 19 <b>67</b> , that <del>the deceased died at</del> <b>3:25 pm</b> , and that death occurred at <b>3:25 M</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Ben Rothfeld</b>						22b. DATE SIGNED <b>5-16-67</b>		22c. PHYSICIAN'S NAME (Type) <b>VA Hospital, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-19-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR <b>Marshall Jones 1735 N. Harford Ave., Balt, Md.</b>	
25a. REC'D BY REGISTRAR <b>MAY 22 1967</b>						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR AIS (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
06570					06554									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b Life 3 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Northeast, Maryland 07-1									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital of Cecil County					d. STREET ADDRESS R.D. 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Cecilia Cecelia			Middle B		Last Preston		4. DATE OF DEATH Month May Day 9 Year 19 67							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/8/93		9. AGE (In years last birthday) 73 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Dennison					14. MOTHER'S MAIDEN NAME Rose Lilly									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 218-54- 1272					17. INFORMANT Mrs. Cecilia Kerns Northeast, Maryland (Daughter) Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema, Congestive Heart Failure 8254 DUE TO (b) Ruptured Spleen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Paralytic Illus and Fractured Ribs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 2- Days 2- Days 2- Days				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year 11 Hour a.m. 5/7/ 19 67 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Cecil Md. (County) Cecil Md. (State)							
21. I certify that (I) (this hospital) attended the deceased from 5/7/ 1967 to 5/9/ 19 67, that (I) (we) last saw the deceased alive on 5/9/ 19 67, and that death occurred at 10:20 P.M. from the causes and on the date stated above.										22b. DATE SIGNED 5/12/67				
22a. SIGNATURE James L. Johnson					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 245 E. High St., Elkton, Md. Cecil							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/13/67		23c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.			23d. LOCATION (City, town or county) North East Md. (State)						
24. FUNERAL DIRECTOR Grant Funeral Home					25a. REC'D BY REGISTRAR J. Charles Judge		25b. REGISTRAR'S SIGNATURE							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06571					06555				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Cecil MARYLAND					a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Rural Elkton				4 mos.	North East 07-1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
00 R.D. 1									
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
AMELIA LOUISE REED					May 12		19 67		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	April 22, 1876		91 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			Home		Philadelphia Co. Penna.		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
William Heidick					Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			None		Frank C. Reed		R.D. 1 Box 189 Elkton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>12 yrs</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>47</u> , to <u>12 May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8 May</u> 19 <u>67</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Klaus H. Huebner</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/12/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>KLAUS H. HUEBNER M.D.</u>					22d. ADDRESS <u>NORTH EAST, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			5/15/67		North East Meth. Cem.		North East Md.		
24. FUNERAL DIRECTOR <u>Paul P. Crouch</u> Grant Funeral Home					25a. REC'D BY REGISTRAR <u>MAY 16 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		

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MAY 19 1961

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06572

CERTIFICATE OF DEATH

06556

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>18 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>			d. STREET ADDRESS <b>R.D. # 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl A. Robinson</b>			4. DATE OF DEATH Month Day Year <b>May 29, 1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1908</b>	9. AGE (In years lost birthday) <b>58 yrs.</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Adm. Assistant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>duPont Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Charles A. Robinson</b>			14. MOTHER'S MAIDEN NAME <b>Ida Wheeler</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>164-05-8667</b>		17. INFORMANT <b>Mrs. Janet B. Robinson, Elkton, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Coronary Artery Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 hr</b> <b>4 wks</b> <b>4 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-22, 1967</b> , to <b>5-29, 1967</b> , that (I) (we) last saw the deceased alive on <b>5-29-1967</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <i>Tillman D. Johnson</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-29-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Tillman D. Johnson</b>		22d. ADDRESS <b>123 Singlerly Ave. Elkton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>June 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Wilmington, Del.</b>	
24. FUNERAL DIRECTOR <i>Nicholas E. Hicks</i> <b>Nicholas E. Hicks</b>		ADDRESS <b>Elkton Md</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 5 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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24. FUNERAL DIRECTOR Richard Sheetz Perryville, Md.  
RICHARD SHEETZ FUNERAL HOME- ROHRESTOWN, Pa.

06573

1. PLACE OF DEATH a. COUNTY						Cecil MARYLAND																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN lb																	
Perry Point						793 days																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)														e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
VA Hospital						104 Blossom Hill Drive																	
3. NAME OF DECEASED (Type or print)						First			Middle			Last			4. DATE OF DEATH			Month Year Day					
Oscar Otto ROCHOW															May 23,			19 67					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH				9. AGE (In years last birthday) 73 yrs.				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
Male		White				4 22 1894																	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
												Columbia, Pa.						U.S.A.					
13. FATHER'S NAME Ernest G.J. Rochow (Deceased)												14. MOTHER'S MAIDEN NAME Amelia Kellar											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I						16. SOCIAL SECURITY NO. 186-38-82-46				17. INFORMANT Address VA Hospital Records - Perry Point, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosisclerosis, generalized																		INTERVAL BETWEEN ONSET AND DEATH 4-7 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Hypertensive cardio-vascular Disease																		19. WAS AUTOPSY PERFORMED? YES XX NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that (X) (this hospital) attended the deceased from 3-18-65, 19 , to 5-23-67, 19 , that it was removed from care between _____, and that death occurred at 2:05 PM, from causes and on the date stated above																							
22a. SIGNATURE S. Goldgraben						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED pm 5-24-67													
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.						22d. ADDRESS VA Hospital - Perry Point, Md.																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF May 27, 1967				23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery				23d. LOCATION (City or Town) (County) (State) Lancaster, Penna.									
24. FUNERAL DIRECTOR Richard Sheepz Funeral Home - Rohrestown, Pa.						25a. FILED BY EDS STRAUB MAY 29 1967				25b. REGISTRAR'S SIGNATURE Judge													

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA Hospital</b>		d. STREET ADDRESS <b>7539 9th St N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Patrick</b> Middle <b>H.</b> Last <b>SEABROOKS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>8 30 13</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Savannah, Ga.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Seabrooks</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Travers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>255-03-95-21</b>	
17. INFORMANT <b>VA Hospital Records - Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralytic ileus due to</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>acute hemorrhagic pancreatitis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>6-8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe fatty liver / Lower nephron nephrosis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from <b>5 11 67</b> , 19 to <b>5 14 67</b> , 19, and that death occurred at <b>9:35 a.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>S. Goldgraben</b>		22b. DATE SIGNED <b>5-15-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>S. GOLDGRABEN, M.D.</b>		22d. ADDRESS <b>VA Hospital - Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-18-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Md.</b>	
24. FUNERAL DIRECTOR <b>Rhines Funeral Home, 3015 12th St., NE., Wash.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06573		06559	
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		d. STREET ADDRESS <b>154 Hollingsworth Manor</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank A. Smith</b>		4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1913</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gordy Enterprizes Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. Robert Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Collins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-2033</b>	
17. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18. MOTHER'S MAIDEN NAME <b>Mrs. Carrie Elizabeth Smith, Elkton Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO (b) <b>Post Hepatic Cirrhosis</b> DUE TO (c) <b>Chronic Alcoholism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/1</b> , 19 <b>67</b> , to <b>5/2</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>5/1</b> , 19 <b>67</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.		22. SIGNATURE <b>Rolando A. Najera</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22a. PHYSICIAN'S NAME (Type) <b>Rolando A. Najera</b>		22b. DATE SIGNED <b>5/2/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Rolando A. Najera</b>		22d. ADDRESS <b>105 E. Main St. Elkton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/6/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bethel, Cecil Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Hicks Home for Funerals, Elkton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 8 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		25c. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06576

CERTIFICATE OF DEATH

06560

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital of Cecil County</b>		d. STREET ADDRESS <b>Earleville</b>	
3. NAME OF DECEASED (Type or print) <b>Walter Taney</b>		4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAPER, CO.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>
13. FATHER'S NAME <b>Thomas Taney</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown No</b>		16. SOCIAL SECURITY NO. <b>159-10-7131A</b>	17. INFORMANT <b>MABEL OPDENARER SPINFIELD, PA.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Severe Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Arteriosclerosis</b> DUE TO (c) <b>Severe Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Probable Gram-negative Septicemia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>24 May, 1967</b> , to <b>29 May, 1967</b> , that (I) (we) last saw the deceased alive on <b>29 May, 1967</b> , and that death occurred at <b>2:05 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Wallace Obenshain</b>		22b. DATE <b>30 May 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wallace Obenshain</b>		22d. ADDRESS <b>Cecilton, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6-2-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>EASTLAWN</b>	23d. LOCATION (City or Town) (County) (State) <b>SWARTHMORE PA.</b>
24. FUNERAL DIRECTOR <b>Pippin Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JUN 1 1967</b>	
ADDRESS <b>ELKTON, MD</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

04281



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06577

06561

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN lb <b>1 day</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VA HOSPITAL</b>				d. STREET ADDRESS <b>Box 183</b>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>W.</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>19 67</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>June 23, 1915</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>News carrier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>newspaper</b>		11. BIRTHPLACE (State or foreign country) <b>Perryville, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John W. Thomas</b>			
14. MOTHER'S MAIDEN NAME <b>Dora M. Griffith</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWII</b>			
16. SOCIAL SECURITY NO. <b>216-01-7792</b>				17. INFORMANT <b>VA Hospital Records, Perry Point, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <b>Tillman D. Johnson, M.D.</b>				22. DATE SIGNED <b>5-13-67</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>May 16, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Port Deposit, Cecil, Md.</b>				24. FUNERAL DIRECTOR <b>Lee A. Patterson &amp; Son, Perryville, Md.</b>			
25a. REC'D BY REGISTRAR <b>MAY 19 1967</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write FULLY and give nearest town) Chesapeake c. LENGTH OF STAY IN 1b Elkton 6 Weeks		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Elkton Hospital - Union		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last William J. Weaver		4. DATE OF DEATH Month Day Year May 14, 1967 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1893
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY U.S. Eng. Dept.	
11. BIRTHPLACE (County & State, or foreign country) Delaware City, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William J. Weaver		14. MOTHER'S MAIDEN NAME Mary Bredemeier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Mullen, 204 Rodman Rd., Wilm., Del.		Address Bellefonte	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDITIS DUE TO 592X (b) CHRONIC NEPHRITIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH SEVERAL MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 10, 1966, to May 14, 1967, that (I) (we) lost saw the deceased alive on May 14, 1967, and that death occurred at 4:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Henry K. Davis M.D.		22b. DATE SIGNED 5/14/67	
22c. PHYSICIAN'S NAME (Type) Henry K. Davis M.D.		22d. ADDRESS My Chesapeake City Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Hickory Grove Cemetery	23d. LOCATION (City or Town) (County) (State) New Castle County, Del.
24. FUNERAL DIRECTOR Ray E. Hicks		25a. REC'D BY REGISTRAR DATE MAY 16 1967	
Hicks Funeral Home, Elkton, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME  
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
06573		Item 2 Film Q389 5/31/67		06563					
1. PLACE OF DEATH e. COUNTY		CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		WARRICK FLEXIN		c. LENGTH OF STAY IN TB		b. COUNTY			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		UNION HOSPITAL		d. STREET ADDRESS		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ALBERT		Middle WOOLFORD		Last		4. DATE OF DEATH Month MAY Day 23 Year 1967	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		Colored		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5-23-96		71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
LABORER		CONSTRUCTION		MD		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
FRANK WOOLFORD		MARY WOOLFORD		WARWICK MD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT					
				MARY WOOLFORD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO SUDEN ONSET AT HOME							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 8 5/23 1967 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) WARWICK		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (Type)		HENRY V. DAVIS MD		DEPUTY MEDICAL EXAMINER		5/23/67			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial		5/27/67		Dale Cemetery		Middletown, Del.			
23. FUNERAL DIRECTOR		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Colin R. Bell		909 Poplar St.		MAY 26 1967		J. Charles Judge			

MEDICAL CERTIFICATION

08500

RECEIVED

08500

08500

TO THE HONORABLE CHIEF OF BUREAU OF LANDS  
WASHINGTON, D. C.

FROM THE HONORABLE CHIEF OF BUREAU OF LANDS  
WASHINGTON, D. C.

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

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12. [Illegible]

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15. [Illegible]

16. [Illegible]

17. [Illegible]

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19. [Illegible]

20. [Illegible]

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

<b>1. PLACE OF DEATH</b> a. COUNTY CECIL		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELKTON		b. COUNTY CECIL	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) UNION HOSPITAL		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ELKTON RURAL	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE L. YATES		d. STREET ADDRESS RD #5 DOGWOOD ROAD	
5. SEX FEMALE		4. DATE OF DEATH Month Day Year MAY 10 1967	
6. COLOR OR RACE WHITE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-28	
9. AGE (In years last birthday) 38 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRIC MOTORS	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM CHARLES		14. MOTHER'S MAIDEN NAME OLGA BANDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT UNION HOSP HOSPITAL RECORDS ELKTON MD			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) FRACTURED PELVIS CRUSHED LEFT KIDNEY			
DUE TO (b) RETROPERITONEAL HEMORRHAGE			
DUE TO (c) AUTO ACCIDENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CROSSING HIGHWAY WHEN STRUCK AND RUN OVER BY AUTO			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) STREET			
20f. (City or town) (County) (State) ELKTON CECIL MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) HENRY V. DAVIS MD ONE SALTIC CITY MD 5/19/67			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			
22b. DATE THEREOF 5/13/67			
22c. NAME OF CEMETERY OR CREMATORY YATES Cemetery			
22d. LOCATION (City, town, or county) (State) GRUNDY VA.			
23. FUNERAL DIRECTOR RICKS HOME FOR FUNERALS, INC. ADDRESS ELKTON			
24a. REC'D BY REGISTRAR DATE MAY 15 1967			
24b. REGISTRAR'S SIGNATURE Charles Judge			

10000

STATE OF ALABAMA

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CHIEF JUDGE

MAY 1 1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06581

06565

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton R.D. # 3</b> 07.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>Blue Ball</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Horace T. Yerkes</b>				4. DATE OF DEATH Month Day Year <b>May 3, 1967</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 23, 1893</b>		9. AGE (In years last birthday) <b>73</b> yrs.		
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fabricator</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Fibre Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clinton J. Yerkes</b>				14. MOTHER'S MAIDEN NAME <b>Jennie Taylor</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-18-8733</b>		17. INFORMANT <b>Blue Ball</b> Address <b>R.D. # 3</b>		Mrs. Esther M. Yerkes, Elkton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitotic Metaplastic Lesion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of lower jaw</b> DUE TO (c) <b>Cancer of lower lip</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>1 1/2 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe secondary cancer</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> , 19 <b>67</b> , to <b>5/3</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>5/3</b> , 19 <b>67</b> , and that death occurred at <b>6:22</b> AM, from causes and on the date stated above.										
22a. SIGNATURE <b>Peter Stavakis</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/5/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Peter Stavakis</b>				22d. ADDRESS <b>154 W. Main St. Elkton, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/7/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Bank Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Calvert, Cecil Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Hicks Home for Funerals, Elkton, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 8 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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12584

Genl

Genl

Elston R.D. No. 3

Elston

Blane Hall

Union Hospital

Yorker

Horace

Sept. 22, 1932

Miss White

Yorker

Yorker Co.

Yorker

Lennie Taylor

Elston 3, Yorker

Oliver Hall

921-1-3753 Mrs. Arthur J. Yorker, Elston, Ill.

Peter Stevakin

154 E. Main St., Elston, Ill.

Elston 5/1/37

Post Bank Company

Elston, Ill.

MAY 8 1937

Elston 5/1/37